



Michigan House of Representatives Medical Coverage Options October 1, 2013 to September 30, 2014

	Community Blue P.P.O. #1		Community Blue P.P.O. #2		Blue Care Network HMO *	Flex Blue Health Savings Account ** (Calendar Year)
	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>		
Costs						
Premium	Single - \$6,442 Two Person - \$14,940 Family - \$19,327		Single - \$5,892 Two Person - \$13,279 Family - \$17,675		Single - \$5,523 Two Person - \$13,255 Family - \$16,569	Single - \$4,248 Two Person - \$10,198 Family - \$12,746
Employee Premium Contribution	20%		10%		10%	0%
Deductible: Annual	\$250/\$500	\$500/\$1,000	\$500/\$1,000	\$1,000/\$2,000	\$250/\$500	\$2,000/\$4,000
Percent Copay	0%	40% - unless otherwise noted	10% - unless otherwise noted	40% - unless otherwise noted	10% - unless otherwise noted	20% - unless otherwise noted
Out-of-Pocket Copay Dollar Maximums (excludes in-patient mental health care, substance abuse and private duty nursing copays)	\$0	\$3,000/\$6,000	\$1,000/\$2,000	\$3,000/\$6,000	\$500/\$1,000	\$500/\$1,000
Preventative Care Services One per Member per calendar year						
Health Maintenance Exam -- includes chest x-ray, EKG, cholesterol screening and other select lab procedures	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%



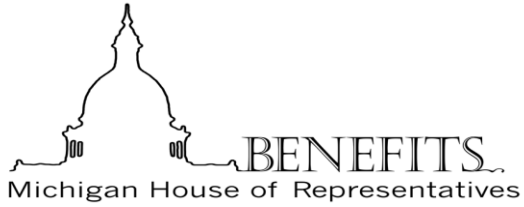
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Preventative Care Services (cont.)						
Gynecological Exam	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%
Pap Smear Screening - laboratory and pathology services	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%
Well-Baby and Child Care	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%
Immunizations - Adult and childhood immunizations as recommended by the Advisory Committee on Immunization practices. Note: Immunizations for travel to foreign countries are not covered.	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%
Fecal Occult Blood Screening	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%
Flexible Sigmoidoscopy Exam	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%
Prostate Specific Antigen (PSA) Screening	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Covered - 100%
Colonoscopy - routine	Covered - 100% once annually	Not Covered	Covered - 100% once annually	Not Covered	Covered - 100% once annually	Covered - 100% once annually
Mammogram and related testing - routine	Covered - 100% once annually	Not Covered	Covered - 100% once annually	Not Covered	Covered - 100% once annually	Covered - 100% once annually



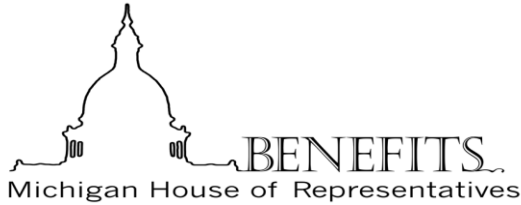
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Physician Services							
Office Visits	Covered - \$10 copay	Covered - 60% after deductible		Covered - \$20 copay	Covered - 60% after deductible	Covered - \$10 copay	Covered - 80% after deductible
Outpatient and Home Visits	Covered - 100% after deductible	Covered - 60% after deductible		Covered - 90% after deductible	Covered - 60% after deductible	Covered - \$10 copay	Covered - 80% after deductible
Office Consultations	Covered - \$10 copay	Covered - 60% after deductible		Covered - \$20 copay	Covered - 60% after deductible	Covered - \$10 copay after deductible	Covered - 80% after deductible
Emergency Medical Care							
Hospital Emergency Room	Covered - \$100 copay, waived if admitted or for an accidental injury	Covered - \$100 copay, waived if admitted or for an accidental injury		Covered - \$100 copay, waived if admitted or for an accidental injury	Covered - \$100 copay, waived if admitted or for an accidental injury	Covered - \$50 copay, waived if admitted or for an accidental injury	Covered 80% after deductible
Urgent Care Center	Covered - \$10 copay	Covered - 60% after deductible		Covered - \$20 copay	Covered - 60% after deductible	Covered - \$35 copay	Covered - 80% after deductible
Ambulance Services - medically necessary	Covered - 100% after deductible	Covered - 80% after deductible		Covered - 90% after deductible	Covered - 80% after deductible	Covered - 90% after deductible	Covered - 80% after deductible



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Diagnostic Services						
Laboratory and Pathology Tests	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered, office visit may apply	Covered - 80% after deductible
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Therapeutic Radiology	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Maternity Services						
Pre-Natal and Post-Natal Care - Includes covered services provided by a certified nurse midwife.	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible	Covered - \$10 copay	Covered - 80% after deductible
Delivery and Nursery Care - Includes covered services provided by a certified nurse midwife.	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 100%	Covered - 80% after deductible
Hospital Services						
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies, Specialty Care Units	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible



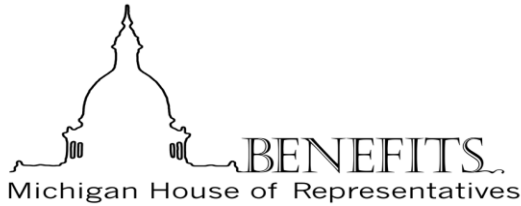
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Hospital Services (cont.)						
Inpatient Consultations	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Surgery	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Voluntary Sterilization	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 50% after deductible	Covered - 80% after deductible
Chemotherapy	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Alternatives to Hospital Care						
Skilled Nursing Facility - Combined 120 days per calendar year	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 90% after deductible - 45 days annual max.	Covered - 80% after deductible - 90 days annual max.
Home Health Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 90% after deductible	Covered - 80% after deductible	Covered - \$10 copay after deductible	Covered - 80% after deductible
Home Infusion Therapy -- must be medically necessary	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Hospice Care	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 80% after deductible
Note: Up to 28 pre-hospice counseling visits before electing hospice services; when elected, for 90 day periods--provided through a participating hospice program only; limited to the dollar maximum that is reviewed and adjusted periodically.						



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Human Organ Transplants						
Specified human organ transplants when coordinated through the BCBSM Human Organ Transplant Program in an approved facility.	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 90% after deductible	Covered - 80% after deductible
Bone marrow transplants--when coordinated through the BCBSM Human Organ Transplant Program	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Kidney, cornea and skin transplant	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Specified oncology clinical trials	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Mental Health & Substance Abuse						
Inpatient Mental Health Care, unlimited days	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Inpatient Substance Abuse Care, unlimited days	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - \$10 copay after deductible	Covered - 80% after deductible
Mental Health & Substance Abuse (cont.)						
Physician's office	\$10 copay per visit	Covered - 60% after deductible	\$20 copay per visit	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 80% after deductible



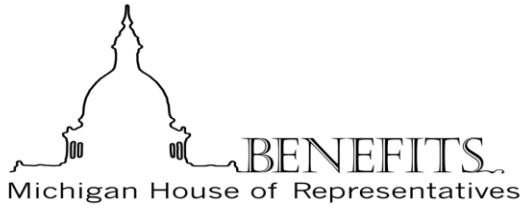
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Facility and Clinic	Covered - 100% after deductible	Covered - 80% after deductible		Covered - 90% after deductible	Covered - 80% after deductible	Covered - 90% after deductible	Covered - 80% after deductible
Outpatient substance abuse treatment in an approved facilities only	\$10 copay per visit	Covered - 60% after deductible		\$20 copay per visit	Covered - 60% after deductible	Covered - 50% (20 visit max.)	Covered - 80% after deductible
Other Services							
Hearing Aid Testing & Treatment	Covered - copays apply (every 36 months)	Covered - copays apply (every 36 months)		Covered - copays apply (every 36 months)	Covered - copays apply (every 36 months)	Covered - copays apply (every 36 months)	Covered - 80% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 60%		Covered - 100%	Covered - 60%	Covered - 50% after deductible	Covered - 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment - Up to a combined maximum of 24 visits per member per calendar year	Covered- \$10 copay	Covered - 60% after deductible		Covered- \$20 copay	Covered - 60% after deductible	Covered - \$10 copay (unlimited)	Not Covered
Outpatient Physical, Speech and Occupational Therapy - Limited to a combined maximum of 60 visits per member per calendar year	Covered - 100% after deductible	Covered - 60% after deductible		Covered - 90% after deductible	Covered - 60% after deductible	Covered - \$10 copay after deductible	Covered - 80% after deductible
Other Services (cont.)							
Durable Medical Equipment	Covered - 100% after deductible	Covered - 60% after deductible		Covered - 90% after deductible	Covered - 60% after deductible	Covered - 50%	Covered - 80% after deductible



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Prosthetic and Orthotic Appliances	Covered - 100% after deductible	Covered - 60% after deductible		Covered - 90% after deductible	Covered - 60% after deductible		Covered - 50%	Covered - 80% after deductible
Private Duty Nursing	Covered - 50% after deductible	Covered - 50% after deductible		Covered - 50% after deductible	Covered - 50% after deductible		Covered - 50%	Covered - 80% after deductible
Outpatient Diabetes Management Program (ODMP)	Covered - 100% after deductible	Covered - 60% after deductible		Covered - 90% after deductible	Covered - 60% after deductible		Covered - 50%	Covered - 80% after deductible
Prescription Drugs, included with medical coverage								
	\$15/generic			\$15/generic			\$15/generic	\$10/generic
	\$30/brand name			\$30/brand name			\$30/brand name	\$60/brand name
	\$50/Non-formulary			\$50/Non-formulary			\$50/Non-formulary	Co-pays apply after deductible
Vision, included with BCN								
	Not Covered - separate vision plan needed	Not Covered - separate vision plan needed		Not Covered - separate vision plan needed	Not Covered - separate vision plan needed		\$5 copay - exam	Not Covered - separate vision plan needed



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				\$10.00 copy lenses & frame	
				\$130 max on frames	
				\$130 max on contact lenses	

* BCN Rates vary by region

Mid-Michigan

Southeast

Single - \$5,523
Two Person - \$13,255
Family - \$116,569

Single - \$5,177



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East					Two Person - \$12,424 Family - \$15,531	
					Single - \$5,037 Two Person - \$12,087 Family - \$15,108	
					Single - \$4,919 Two Person - \$11,804 Family - \$14,759	

** Flex Blue - Health Savings Account
Contribution to Account by the House

Single - \$1,000*
Two Person - \$1,500*
Family - \$2,000*

*Pro-rated for New Hires